		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043398

Facility Name: BURNHAM HEALTHCARE

Address: 14500 S. MANISTEE (Number) BURNHAM (City) 60633 (Zip Code)

County: COOK

Telephone Number: (708) 862 - 1200 **Fax #** (708) 862 - 1263

IDPA ID Number: 36-4205217

Date of Initial License for Current Owners: 03/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MORRIS ESFORMES

(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,595	1
2		Skilled Pediatric (SNF/PED)			2
3	206	Intermediate (ICF)	206	75,190	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	309	TOTALS	309	112,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,098	228	7,835	38,161	8
9	SNF/PED					9
10	ICF	71,659	804	253	72,716	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	101,757	1,032	8,088	110,877	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.31%

D. How many bed-hold days during this year were paid by Public Aid?
1,151 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 7,594

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	292,361	35,982	17,130	345,473		345,473		345,473			1
2	Food Purchase		387,977		387,977	(10,311)	377,666	(1,776)	375,890			2
3	Housekeeping	261,254	39,075		300,329		300,329		300,329			3
4	Laundry	119,733	27,800	9,931	157,464		157,464		157,464			4
5	Heat and Other Utilities			175,193	175,193		175,193	626	175,819			5
6	Maintenance	134,466	37,182	81,181	252,829		252,829	5,196	258,025			6
7	Other (specify):*			67,120	67,120		67,120	216	67,336			7
8	TOTAL General Services	807,814	528,016	350,555	1,686,385	(10,311)	1,676,074	4,262	1,680,336			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,155,513	149,404	23,829	3,328,746		3,328,746		3,328,746			10
10a	Therapy	105,924	11,804	12,743	130,471		130,471		130,471			10a
11	Activities	119,187	27,363	3,828	150,378		150,378		150,378			11
12	Social Services	157,684		5,849	163,533		163,533		163,533			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,538,308	188,571	52,249	3,779,128		3,779,128		3,779,128			16
	C. General Administration											
17	Administrative	124,477		580,000	704,477		704,477	(513,247)	191,230			17
18	Directors Fees											18
19	Professional Services			107,398	107,398		107,398	15,431	122,829			19
20	Dues, Fees, Subscriptions & Promotions			25,088	25,088		25,088	(7,712)	17,376			20
21	Clerical & General Office Expenses	224,632	30,232	149,825	404,689		404,689	(70,587)	334,102			21
22	Employee Benefits & Payroll Taxes			756,046	756,046	10,311	766,357		766,357			22
23	Inservice Training & Education							131	131			23
24	Travel and Seminar			6,464	6,464		6,464	139	6,603			24
25	Other Admin. Staff Transportation			5,856	5,856		5,856	1,023	6,879			25
26	Insurance-Prop.Liab.Malpractice			246,958	246,958		246,958	3,994	250,952			26
27	Other (specify):* BAD DEBTS			757,435	757,435		757,435	(743,010)	14,425			27
28	TOTAL General Administration	349,109	30,232	2,635,070	3,014,411	10,311	3,024,722	(1,313,838)	1,710,884			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,695,231	746,819	3,037,874	8,479,924		8,479,924	(1,309,576)	7,170,348			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BURNHAM HEALTHCARE #0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			551,519	551,519		551,519	(48,267)	503,252			30
31	Amortization of Pre-Op. & Org.			47,441	47,441		47,441		47,441			31
32	Interest			1,177,188	1,177,188		1,177,188	(23,557)	1,153,631			32
33	Real Estate Taxes			623,096	623,096		623,096	1,733	624,829			33
34	Rent-Facility & Grounds			21,476	21,476		21,476	(21,476)				34
35	Rent-Equipment & Vehicles			34,130	34,130		34,130	7,137	41,267			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,454,850	2,454,850		2,454,850	(84,430)	2,370,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		169,653	371,022	540,675		540,675		540,675			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,177	169,177		169,177		169,177			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		169,653	540,199	709,852		709,852		709,852			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,695,231	916,472	6,032,923	11,644,626		11,644,626	(1,394,006)	10,250,620			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(50,964)	30		9
10	Interest and Other Investment Income	(16,493)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,776)	2		13
14	Non-Care Related Interest	(10,000)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(12,675)	21		18
19	Entertainment		20		19
20	Contributions	(8,894)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(757,435)	27		24
25	Fund Raising, Advertising and Promotional	(993)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(184,273)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,043,503)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(350,503)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (350,503)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,394,006)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BURNHAM HEALTHCARE

ID# 0043398

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	MARKETING SALARY	(48,261)	21	2
3	BANK CHARGES	(339)	21	3
4	STAFF DEVELOPMENT	(15,673)	21	4
5	PHILLIP ESFORME'S MANAGEMENT FEES	(120,000)	17	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(184,273)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,776)	0	0	0	0	0	0	0	0	0	0	(1,776)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	626	0	0	0	0	0	0	0	626	5
6	Maintenance	0	0	4,112	1,084	0	0	0	0	0	0	0	5,196	6
7	Other (specify):*	0	0	216	0	0	0	0	0	0	0	0	216	7
8	**TOTAL General Services**	(1,776)	0	4,328	1,710	0	0	0	0	0	0	0	4,262	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(120,000)	(409,123)	15,876	0	0	0	0	0	0	0	0	(513,247)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	461	14,576	394	0	0	0	0	0	0	0	15,431	19
20	Fees, Subscriptions & Promotions	(9,887)	0	2,175	0	0	0	0	0	0	0	0	(7,712)	20
21	Clerical & General Office Expenses	(76,948)	14,562	(8,397)	196	0	0	0	0	0	0	0	(70,587)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	131	0	0	0	0	0	0	0	0	131	23
24	Travel and Seminar	0	0	139	0	0	0	0	0	0	0	0	139	24
25	Other Admin. Staff Transportation	0	812	211	0	0	0	0	0	0	0	0	1,023	25
26	Insurance-Prop.Liab.Malpractice	0	1,765	2,071	158	0	0	0	0	0	0	0	3,994	26
27	Other (specify):*	(757,435)	4,462	9,963	0	0	0	0	0	0	0	0	(743,010)	27
28	**TOTAL General Administration**	(964,270)	(387,061)	36,745	748	0	0	0	0	0	0	0	(1,313,838)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(966,046)	(387,061)	41,073	2,458	0	0	0	0	0	0	0	(1,309,576)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **BURNHAM HEALTHCARE** **#** **0043398** **Report Period Beginning:** **01/01/2002** **Ending:** **12/31/2002**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(50,964)	585	782	1,330	0	0	0	0	0	0	0	(48,267)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,493)	0	0	2,936	0	0	0	0	0	0	0	(23,557)	32
33	Real Estate Taxes	0	0	0	1,733	0	0	0	0	0	0	0	1,733	33
34	Rent-Facility & Grounds	0	0	0	(21,476)	0	0	0	0	0	0	0	(21,476)	34
35	Rent-Equipment & Vehicles	0	2,056	4,764	317	0	0	0	0	0	0	0	7,137	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(77,457)	2,641	5,546	(15,160)	0	0	0	0	0	0	0	(84,430)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,043,503)	(384,420)	46,619	(12,702)	0	0	0	0	0	0	0	(1,394,006)	45

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		LIST ATTACHED		EKS MNGT	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISE	LINCOLNWOOD	CONSULTING
				IME REALTY CORP	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 435,000	EMI ENTERPRISE		$	$ (435,000)	1
2	V								2
3	V	17	OFFICERS SALARY				25,877	25,877	3
4	V	19	ACCOUNTING FEES				461	461	4
5	V	21	OFFICE EXPENSE				14,562	14,562	5
6	V	25	TRANSPORTATION				812	812	6
7	V	26	INSURANCE				1,765	1,765	7
8	V	27	EMPLOYEE BENEFITS				4,462	4,462	8
9	V	30	DEPRECIATION				585	585	9
10	V	35	AUTO LEASE				2,056	2,056	10
11	V								11
12	V								12
13	V								13
14	Total			$ 435,000			$ 50,580	$ * (384,420)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKEEPING FEES	$ 60,000	EKS MANAGEMENT		$	$ (60,000)	15
16	V								16
17	V	6	PAINTING / DECORATING		" "		4,112	4,112	17
18	V	7	SCAVENGER		" "		216	216	18
19	V	17	CFO SALARY		" "		15,876	15,876	19
20	V	19	PROFESSIONAL FEES		" "		14,576	14,576	20
21	V	20	WANTS AD		" "		2,175	2,175	21
22	V	21	OFFICE EXPENSE		" "		51,603	51,603	22
23	V	23	SEMINARS		" "		131	131	23
24	V	24	IN STATE LODGING MEALS		" "		139	139	24
25	V	25	TRANSPORTATION		" "		211	211	25
26	V	26	INSURANCE		" "		2,071	2,071	26
27	V	27	EMPLOYEE BENEFITS		" "		9,963	9,963	27
28	V	30	DEPRECIATION		" "		782	782	28
29	V	35	EQUIPMENT RENT				4,764	4,764	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,000			$ 106,619	$ * 46,619	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	OFFICE RENT	$ 21,476	IME REALTY CORP		$	$ (21,476)	15
16	V								16
17	V	5	UTILITIES		" "		626	626	17
18	V	6	REPAIRS & MAINTENANCE		" "		1,084	1,084	18
19	V	19	PROFESSIONAL FEES		" "		394	394	19
20	V	21	OFFICE EXPENSE		" "		196	196	20
21	V	26	INSURANCE		" "		158	158	21
22	V	30	DEPRECIATION		" "		1,330	1,330	22
23	V	32	INTEREST		" "		2,936	2,936	23
24	V	33	RE TAX				1,733	1,733	24
25	V	35	STORAGE FEES				317	317	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,476			$ 8,774	$ * (12,702)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	OFFICER	MANAGEMENT	0.38	159,123	See Attached		MNGT FEES	$ 25,877	17-8	1
2	PHILIP ESFORMES	MEMBER	MANAGEMENT	0.19		See Attached		MNGT FEES	25,000	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 50,877		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	797,100	13	$ 185,000	$ 185,000	111,497	$ 25,877	1
2	19	ACCOUNTING FEES	PATIENT DAYS	797,100	13	3,299		111,497	461	2
3	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	104,106	76,720	111,497	14,562	3
4	25	TRANSPORTATION	PATIENT DAYS	797,100	13	5,805		111,497	812	4
5	26	INSURANCE	PATIENT DAYS	797,100	13	12,620		111,497	1,765	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	31,900		111,497	4,462	6
7	30	DEPRECIATION	PATIENT DAYS	797,100	13	4,180		111,497	585	7
8	35	AUTO LEASE	PATIENT DAYS	797,100	13	14,702		111,497	2,056	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 361,612	$ 261,720		$ 50,580	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING & DECORATING	PATIENT DAYS	797,100	13	$ 29,397	$ 29,397	111,497	$ 4,112	1
2	7	SCAVENGER	PATIENT DAYS	797,100	13	1,544		111,497	216	2
3	17	CFO SALARY	PATIENT DAYS	797,100	13	113,499	113,499	111,497	15,876	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	797,100	13	104,205		111,497	14,576	4
5	20	WANTS AD	PATIENT DAYS	797,100	13	15,548		111,497	2,175	5
6	21	TOTAL OFFICE	PATIENT DAYS	797,100	13	368,910	256,444	111,497	51,603	6
7	23	SEMINARS	PATIENT DAYS	797,100	13	940		111,497	131	7
8	24	IN STATE LODGING MEALS	PATIENT DAYS	797,100	13	994		111,497	139	8
9	25	TRANSPORTATION	PATIENT DAYS	797,100	13	1,506		111,497	211	9
10	26	INSURANCE	PATIENT DAYS	797,100	13	14,803		111,497	2,071	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	71,229		111,497	9,963	11
12	30	DEPRECIATION	PATIENT DAYS	797,100	13	5,592		111,497	782	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	797,100	13	34,056		111,497	4,764	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 762,223	$ 399,340		$ 106,619	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N. LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	268,762	13+FACIL	$ 7,839	$	21,476	$ 626	1
2	6	REPAIRS & MAINTENANCE	INCOME	268,762	13+FACIL	13,572		21,476	1,084	2
3	19	PROFESSIONAL FEES	INCOME	268,762	13+FACIL	4925		21,476	394	3
4	21	OFFICE EXPENSE	INCOME	268,762	13+FACIL	2,448		21,476	196	4
5	26	INSURANCE	INCOME	268,762	13+FACIL	1,978		21,476	158	5
6	30	DEPRECIATION	INCOME	268,762	13+FACIL	16,647		21,476	1,330	6
7	32	INTEREST	INCOME	268,762	13+FACIL	36,747		21,476	2,936	7
8	33	RE TAX	INCOME	268,762	13+FACIL	21,685		21,476	1,733	8
9	35	STORAGE FEES	INCOME	268,762	13+FACIL	3,962		21,476	317	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,803	$		$ 8,774	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	COLE TAYLOR BANK		X	MORTGAGE	$116,941.00	5/24/00	$ 15,700,000	$ 15,238,149	06/01/05	0.0875	$ 1,167,188	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$116,941.00		$ 15,700,000	$ 15,238,149			$ 1,167,188	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11	COLE TAYLOR		X	LOAN COVENANT							10,000	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 10,000	14
15	TOTALS (line 9+line14)						$ 15,700,000	$ 15,238,149			$ 1,177,188	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 586,702	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 604,899	2
3. Under or (over) accrual (line 2 minus line 1).		$ 18,197	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 604,899	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 623,096	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	505,388	8
	1998	516,010	9
	1999	577,666	10
	2000	586,702	11
	2001	604,899	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BURNHAM HEALTHCARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043398

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-06-313-040-000 VOL 220		$ 492,803.00	$ 492,803.00
2.	30-06-313-054-000 VOL 220		$ 72,965.00	$ 72,965.00
3.	30-06-313-053-000 VOL 220		$ 5,151.00	$ 5,151.00
4.	30-06-313-052-000 VOL 220		$ 7,827.00	$ 7,827.00
5.	30-06-313-051-000 VOL 220		$ 24,015.00	$ 24,015.00
6.	30-06-313-045-000 VOL 220		$ 2,138.00	$ 2,138.00
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 604,899.00	$ 604,899.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,554 B. General Construction Type: Exterior 3 STORY Frame BRICK Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1998	$ 1,500,000	1
2					2
3	TOTALS			$ 1,500,000	3

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	309		1998		$ 12,649,700	$ 324,351	39	$ 324,351	$	$ 1,554,182	4
5											5
6											6
7	RELATED PARTY					1,090		1,090			7
8											8
	Improvement Type**										
9	ROOF			1998	74,000	1,898	39	1,898		8,620	9
10	WALLCOVERINGS			1998	39,379	1,009	39	1,009		4,583	10
11	PAINTING			1998	12,962	333	39	333		1,512	11
12	WINDOW TREATMENTS			1998	38,112	977	39	977		4,437	12
13	FENCE			1998	650	17	39	17		77	13
14	NEW WINDOWS			1998	20,445	524	39	524		2,380	14
15	PAINTERS SALARIES			1998	64,064	1,643	39	1,643		7,462	15
16	NURSE STATION			1998	23,100	592	39	592		2,689	16
17	TILING			1998	635	16	39	16		73	17
18	BUILT IN CABINETRY			1998	64,700	1,659	39	1,659		7,412	18
19	NEW COILS FOR AHV			1998	6,000	154	39	154		545	19
20	NEW BOILER			1998	20,328	521	39	521		1,845	20
21	HOT WATER TANK			1998	2,750	71	39	71		251	21
22	ROOF			1999	29,500	756	15	756		2,678	22
23	PATIO			1999	5,080	339	15	339		1,200	23
24	AWNING			1999	3,000	200	39	200		708	24
25	LIGHTS			1999	7,603	195	39	195		691	25
26	NURSE CALL STATION			1999	1,957	50	39	50		177	26
27	WINDOW TREATMENTS			1999	11,207	287	39	287		1,017	27
28	CORRIDOR BORDERS			1999	6,154	158	27.5	158		559	28
29	SCREENS			2000	3,543	129	27.5	129		328	29
30	AIR CONDITIONER REPLACEMENT			2001	14,540	529	27.5	529		815	30
31	DOOR DETECTOR			2001	1,800	65	27.5	65		100	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER			2001	22,621	823	27.5	823		1,269	32
33	ROOF VENTILATORS			2001	6,898	251	27.5	251		387	33
34	BOILER			2001	63,746	2,318	27.5	2,318		3,574	34
35	WALK IN FREEZER			2001	3,750	136	27.5	136		210	35
36	DOOR			2001	2,970	108	27.5	108		166	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DRYER EXHAUST FAN	2001	$ 4,050	$ 147	27.5	$ 147	$	$ 227	37
38	DOORS	2001	1,995	72	27.5	72		111	38
39	DOORS	2001	1,723	63	27.5	63		97	39
40	FLOOR TILING & CARPETING	2001	4,497	1,439	5	899	(540)	1,798	40
41	DRAPERIES	2001	12,722	4,071	5	2,544	(1,527)	5,088	41
42	HOT WATER HEATER & PIPING	2002	19,857	391	27.5	391		391	42
43	ROOF	2002	6,150	121	27.5	121		121	43
44	ELECTRIC DOOR LOCKING SYSTEM	2002	2,326	46	27.5	46		46	44
45	DOORS	2002	10,098	199	27.5	199		199	45
46	TILING	2002	17,815	351	27.5	351		351	46
47	SAFETY LOCK SYSTEM	2002	5,854	115	27.5	115		115	47
48	ELEVATOR REPAIR	2002	39,650	781	27.5	781		781	48
49	BOILER	2002	9,550	188	27.5	188		188	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,337,481	$ 349,183		$ 347,116	$ (2,067)	$ 1,619,460	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,497,895	$ 161,723	$ 149,790	$ (11,933)	10 YRS	$ 629,010	71
72	Current Year Purchases	94,781	41,703	4,739	(36,964)	10 YRS	4,739	72
73	Fully Depreciated Assets							73
74	IME,EKS,EMI ALLOCATION		1,607	1,607				74
75	TOTALS	$ 1,592,676	$ 205,033	$ 156,136	$ (48,897)		$ 633,749	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,430,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 554,216	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 503,252	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (50,964)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,253,209	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 34,130 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs		$		$ 203,267	$		$ 203,267	1
2	Licensed Speech and Language Development Therapist	39-8	hrs				11,683			11,683	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-8	hrs				144,521			144,521	4
5	Physician Care	39-8	visits				395			395	5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-8	# of prescrpts					159,111		159,111	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): LAB, MED SUPPLIES	39-8					11,156	10,542		21,698	13
14	TOTAL				$		$ 371,022	$ 169,653		$ 540,675	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 150,861	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,372,384		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	170,478		6
7	Other Prepaid Expenses	222,673		7
8	Accounts Receivable (owners or related parties)	293,199		8
9	Other(specify): RE ESCROW DEP	297,165		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,506,760	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000		13
14	Buildings, at Historical Cost	12,649,700		14
15	Leasehold Improvements, at Historical Cost	670,562		15
16	Equipment, at Historical Cost	1,609,895		16
17	Accumulated Depreciation (book methods)	(2,778,219)		17
18	Deferred Charges	237,205		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(122,556)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEP ON FIXED ASSET	106,304		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,872,891	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,379,651	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 351,260	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	262,813		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,764		31
32	Accrued Real Estate Taxes(Sch.IX-B)	604,899		32
33	Accrued Interest Payable	98,453		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO PRIOR OWNER	245,489		36
37	DUE TO RELATED PARTIES	215,964		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,807,642	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	15,238,149		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 15,238,149	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 17,045,791	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 333,860	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,379,651	$	48

***(See instructions.)**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 868,527	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	261,540	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,130,067	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	323,793	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,120,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (796,207)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 333,860	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,866,338	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,866,338	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	112,182	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 112,182	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,493	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,493	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR ADJ	(11,175)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (11,175)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,983,838	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,686,385	31
32	Health Care	3,779,128	32
33	General Administration	3,014,411	33
	B. Capital Expense		
34	Ownership	2,454,850	34
	C. Ancillary Expense		
35	Special Cost Centers	540,675	35
36	Provider Participation Fee	169,177	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,644,626	40
41	**Income before Income Taxes (line 30 minus line 40)****	339,212	41
42	**Income Taxes**	15,419	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 323,793	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,236	4,620	$ 125,505	$ 27.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,185	25,788	649,808	25.20	3
4	Licensed Practical Nurses	44,627	47,077	895,566	19.02	4
5	Nurse Aides & Orderlies	138,265	147,599	1,216,692	8.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,444	10,175	105,924	10.41	8
9	Activity Director					9
10	Activity Assistants	15,379	15,819	119,187	7.53	10
11	Social Service Workers	13,833	14,543	157,684	10.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,761	38,813	292,361	7.53	15
16	Dishwashers					16
17	Maintenance Workers	13,335	14,106	134,466	9.53	17
18	Housekeepers	33,644	36,147	261,254	7.23	18
19	Laundry	16,957	18,060	119,733	6.63	19
20	Administrator	3,027	3,264	124,477	38.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	5,532	5,532	48,261	8.72	23
24	Clerical	12,352	13,014	133,754	10.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,571	8,838	61,556	6.96	31
32	Other Health Care(specify)	12,607	13,602	206,386	15.17	32
33	Other(specify) PURCHASING	2,086	2,086	42,617	20.43	33
34	TOTAL (lines 1 - 33)	394,841	419,083	$ 4,695,231 *	$ 11.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 17,130	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	3,193	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	H	10,571	10-3	39
40	Physical Therapy Consultant	L	3,162	10a-3	40
41	Occupational Therapy Consultant	Y	2,627	10a-3	41
42	Respiratory Therapy Consultant		5,385	10a-3	42
43	Speech Therapy Consultant	F	574	10a-3	43
44	Activity Consultant	E	3,828	11-3	44
45	Social Service Consultant	E	5,849	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 58,319		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOSEF MEYSTEL	ADMIN	0	$ 124,477
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 124,477

B. Administrative - Other

Description	Amount
EMI ENTERPRISE	$ 435,000
PHILIP ESFORMES INC	145,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 580,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		107,398
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 107,398

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 134,147
Unemployment Compensation Insurance	36,518
FICA Taxes	357,285
Employee Health Insurance	193,430
Employee Meals	10,311
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	34,666
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 766,357

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,286
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	993
TRUST/FRANCHISE/CONTRIB/ETC	8,894
LICENSES & PERMITS	3,449
DUES & SUBSCRIPTIONS	9,466
MGMT CO ALLOCATION	2,175
TRUST/FRANCHISE/CONTRIB/ETC	(8,894)
Less: Public Relations Expense	(0)
Non-allowable advertising	(993)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,376

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	139
Seminar Expense	
	6,464
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,603

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL LONG TERM CARE**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,956** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **169,177**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,311** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BURNHAM HEALTHCARE #0043398 **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	17,130	
	REPAIRS & MAINTENANCE		0	
			0	17,130
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		9,931	
			0	9,931
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		52,554	
	ELECTRICITY		74,832	
	WATER		47,807	
	CABLE TV - LOBBY		0	
			0	175,193
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,020	
	PAINTING & DECORATING		1,700	
	BUILDING REPAIRS		11,276	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		37,300	
	ELEVATOR MAINTENANCE & REPAIR		19,367	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,556	
	FIRE SERVICE		3,962	
			0	
			0	
			0	81,181
7	**OTHER**			
	SCAVENGER		22,147	
	SECURITY SERVICE		44,973	67,120
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,193	
	PHARMACY CONSULTANT	XVIII B 39-2	10,571	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	6,000	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		465	
	DENTAL		3,600	23,829
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		995	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,162	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,627	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	5,385	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	574	12,743
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,828	
			0	3,828
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	5,849	
			0	5,849
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BURNHAM HEALTHCARE **#0043398** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	580,000	580,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	25,969	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	81,429	
			0	107,398
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	993	
	EMPLOYEE WANT ADS	XIX F	2,286	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,466	
	LICENSES & PERMITS	XIX F	3,449	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	8,894	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	25,088
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		339	
	EQUIPMENT REPAIR & MAINTENANCE		2,829	
	OUTSIDE CLERICAL SERVICES		84,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	12,675	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		34,309	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		15,673	149,825

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	357,285	
	UNEMPLOYMENT COMPENSATION	XIX D	36,518	
	WORKERS COMPENSATION INSURANC	XIX D	134,147	
	HOSPITALIZATION INSURANCE	XIX D	193,430	
	EMPLOYEE BENEFITS - OTHER	XIX D	34,666	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	756,046
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	6,464	
	TRAVEL	XIX G	0	
			0	
			0	6,464
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,856	5,856
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		246,958	246,958
27	**OTHER**			
	BAD DEBTS	VI 24	757,435	
			0	757,435

GRAND TOTAL COLUMN 3 OTHER 3,037,874

BURNHAM HEALTHCARE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	387,977
LESS SALES TAX	(1,776)
NET FOOD	386,201
TOTAL PATIENT CENSUS	110,877
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	332631
ADD # EMPLOYEE MEALS/DAY	25
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	9125

PATIENT MEALS	332631
ADD EMPLOYEE MEALS	9125
TOTAL MEALS/YEAR	341756
NET FOOD	386201
DIVIDE TOTAL MEALS/YEAR	341756
COST PER MEAL	1.13
TIME EMPLOYEE MEALS	9125
EMPLOYEE MEAL RECLASSIFICATION	10311